Patient Registration / History / Billing Information

PATIENT INFORMATION

Date_____ Soc. Sec. #_____ Birthdate_____Age_____

Name(Last, First, Middle)_____

Address_____ Home Phone_____

City_____ State_____ Zip_____ Mobile Phone_____

Circle Which Apply: Sex: M / F Minor Single Married Divorced Widowed Separated

Employer_____ Work Phone_____

Business Address_____ Occupation_____

How were you referred:_____

In case of an emergency, who should we contact?_____ Phone_____

PRIMARY DENTAL INSURANCE

Person Responsible for Account(Last, First)_____

Relationship to Patient_____ Birthdate_____ Soc. Sec. #_____

Address_____ Home Phone_____

City_____ State_____ Zip_____ Mobile Phone_____

Person Responsible Employer_____ Work Phone_____

Business Address_____ Occupation_____

Dental Insurance Company_____

Insurance Company Address_____

Subscriber I.D. #_____ Group #_____

ADDITIONAL DENTAL INSURANCE

Insured Name(Last, First)_____

Relationship to Patient_____ Birthdate_____ Soc. Sec. #_____

Address_____ Home Phone_____

City_____ State_____ Zip_____ Mobile Phone_____

Insured Employed By_____ Work Phone_____

Dental Insurance Company_____

Insurance Company Address_____

Subscriber I.D. #_____ Group #_____

Please Complete Both Sides of this Form

DENTAL HISTORY

Former Dentist_____ Date of Last X-Rays_____
City, State_____ How Often Do You Floss?_____
Date of Last Dental Visit_____ How Often Do You Brush?_____

Check All That Apply:

__Bad Breath
__Bleeding Gums
__Blisters on Lips or Mouth
__Finger Nail Biting
__Grinding Teeth
__Lip or Cheek Biting
__Loose or Broken Fillings
__Orthodontic Treatment
__Pain Around Ear
__Periodontal Treatment
__Sensitivity to Cold
__Sensitivity to Hot
__Sensitivity to Sweets
__Sensitivity When biting
__Frequent Headaches
__Jaw, Head or Neck Injuries
__Jaw Difficulty: Clicking and/or Pain
__Tooth Pain

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit_____

	Yes	No
1. Are you currently under medical treatment?	___	___
2. Have you ever had any serious illnesses or operations?	___	___
3. Are you currently taking any medication?	___	___
Please Describe:_____		
_____		
_____		
4.Do you smoke?	___	___
5.Do you use alcohol, cocaine, or other drugs?	___	___
6.Do you wear contact lenses?	___	___

	Yes	No
7. Any allergic reactions to:		
Local Anesthetics (e.g. Novocaine)	___	___
Penicillin	___	___
Other Antibiotics	___	___
Sulfa Drugs	___	___
Codeine	___	___
Sedatives	___	___
Iodine	___	___
Aspirin	___	___
Other	___	___

	Yes	No
8. Women Only, Are You:		
Pregnant?	___	___
Nursing?	___	___
Taking birth control pills?	___	___

Check All That Apply:

__AIDS
__Arthritis, Rheumatism
__Artificial Joints
__Asthma
__Bleeding Abnormally
__Diabetes
__Epilepsy
__Fainting or Dizziness
__Heart Murmur
__Heart Problems
__Hepatitis A/B/C
__Herpes
__High Blood Pressure
__HIV Positive
__Latex Sensitivity
__Kidney Disease
__Mitral Valve prolapse
__Pacemaker
__Radiation Treatment
__Rheumatic Fever
__Sinus Trouble
__Skin Rash
__STD
__Thyroid Problems
__Tuberculosis
__Other / Please List

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Barry N. Stein D.D.S. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____Date_____